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CONGRESSIONALLY MANDATED EVALUATION OF THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM

Site Visit Report: The State of Missouri's MC+ for Kids Program

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I. PROGRAM OVERVIEW

Missouri's Title XXI program, "MC+ for Kids," is a Medicaid expansion implemented under Medicaid Section 1115 demonstration authority that covers children in families with incomes up to 300 percent of the Federal Poverty Level (FPL).[1] Missouri's Title XXI plan, submitted in late September, 1997, was the first to arrive at the Health Care Financing Administration (HCFA, now the Centers for Medicare & Medicaid Services, or CMS), largely because the state was able to build upon a previously submitted Section 1115 demonstration application. Both the Section 1115 demonstration, which also extends Medicaid eligibility to certain groups of parents, and the Title XXI plan were approved in April 1998. Enrollment of children began three months later (Table I.1). Missouri is one of 16 states that have opted to use Title XXI funds solely to expand Medicaid coverage.

Administered by the Division of Medical Services within the Department of Social Services (DSS), MC+ for Kids builds on an existing Medicaid managed care program launched in 1995, known as MC+, that is currently operational in 37 counties across the state's central corridor. As a statewide program, MC+ for Kids and the other demonstration components utilize managed care in those counties and fee-for-service arrangements in other (largely rural) areas of the state. A separate division within DSS, the Division of Family Services (DFS), handles the enrollment process.

Although the state originally wanted the entire expansion to occur under a Title XXI demonstration, a compromise with HCFA was reached that permits the state to obtain the enhanced match for the children, while the regular Medicaid matching rate is applied to

[1]This is a gross income threshold.

expenditures for the adult components. And while the various components of the Section 1115 demonstration are being implemented side by side and designed to dovetail with one another, income eligibility thresholds and benefits vary across the different groups. (Tables I.2 and I.3) Adults newly eligible under the demonstration include:

- Parents transitioning off of TANF, with income levels up to 300 percent FPL (for up to 2 years).
- Custodial parents with incomes up to 100 percent FPL (with no time limit).
- Non-custodial parents up to 100 percent FPL and participating in an employment training program called Parents Fair Share, and other non-custodial parents with incomes up to 125 percent FPL if paying legally-obligated child support (for up to 2 years).
- Women who lose Medicaid eligibility after the 60-day postpartum period may continue to be eligible for up to 24 months.

Adult components of the demonstration program took effect in February 1999. As of August 2001, the number of low-income adults enrolled in the demonstration program (89,488) surpassed the number of children enrolled in MC+ for Kids, with by far the largest adult enrollment (77 percent) in the custodial parent category.

In August 2001, 75,221 children were enrolled in MC+ for Kids, 77 percent of the official 90,000 target population figure. Enrollment of children in Title XIX Medicaid also increased significantly with the implementation of MC+ for Kids, reversing the decline that the state had experienced in the aftermath of welfare reform. Using the flexibility afforded under its managed care and Section 1115 demonstration programs, Missouri has put in place an ambitious package of reforms designed both to reduce costs through managed care arrangements and to expand coverage to new groups. Current and future challenges involve ensuring continued support for this large expansion population in the face of state fiscal pressures, and providing sufficient access to care.

This case study is based primarily on a site visit to Missouri conducted June 25-29, 2001, as part of the Congressionally-Mandated Evaluation of the State Children's Health Insurance Program. The visit included interviews with state agency staff, legislators, child health advocates, front-line eligibility workers, health care providers, and staff of organizations involved in outreach and application assistance. (See Appendix A for a list of informants.) To gather information about policy development and local implementation of MC+ for Kids, our time on site was divided between the state capitol (Jefferson City), a major urban center (St. Louis), and a rural area (Cape Giradeau). Additional information about how the program's development and early implementation experiences was provided by the Urban Institute team who studied the Missouri SCHIP program and conducted a site visit in February 2000.

TABLE I.1

SCHIP STATE PLAN AND AMENDMENTS AND RELATED MEDICAID DEMONSTRATIONS

Document	Dates			Description
	Submitted	Approved	Effective	
TITLE XXI SCHIP PLAN				
Initial Submission	9/26/97	4/28/98		Implemented Medicaid expansion, "MC+ for Kids," covering children up to age 19 with family incomes up to 300% of the FPL (gross). The expansion is being implemented under Title XIX Section 1115 demonstration authority.
TITLE XIX SECTION 1115 DEMONSTRATION				
Initial submission	6/30/94			To implement managed care and extend Medicaid eligibility to uninsured adults and children up to 200% of the FPL (net)
Revision	3/24/95			To extend eligibility only to uninsured children under age 19, up to 200% FPL (net)
Review suspended	9/96-9/97			Waiver left in queue while State pursues a Section 1915(b) waiver to implement Medicaid managed care
Revised submission	9/2/97	4/29/98	7/98 children 2/99 parents	To extend eligibility to certain groups of parents, in parallel with expansions for children under Title XXI
Amendment 1		9/98		Modifies/clarifies crowd out policy
Amendment 2		1/29/99		Modifies cost sharing policy (allows disenrollment/ lock-out for nonpayment—more than 3 instances).
TITLE XIX SECTION 1915(B) MANAGED CARE DEMONSTRATION				
Initial submission	10/1/95	10/95		Creates Managed Care Plus (MC+) program, mandating enrollment in managed care arrangements for core (women, children) non-SSI Medicaid populations. Program is phased in gradually across counties based on level of managed care infrastructure.

SOURCE: Centers for Medicare & Medicaid Services (CMS), "Missouri Title XXI state Plan Summary Fact Sheet." (web site (http://www.hcfa.gov/init/chpfsmo.htm); "Missouri Statewide Health Reform Demonstration Fact Sheet. (web site (http://www.hcfa.gov/medicaid/1115/mofact.htm); "The State Of Missouri 1915(b) Program." (web site (http://www.hcfa.gov/medicaid/1915b/mo03fs.htm).

NOTES: SCHIP=State Children's Health Insurance Program. FPL=federal poverty level.

TABLE I.2

MEDICAID AND SCHIP INCOME ELIGIBILITY STANDARDS AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL, CHILDREN'S COMPONENTS

	Age (in Years)			
	Up to 1	1-5	6-17	17-18
Medicaid standards in effect 3/31/97[a]	185%	133%	100%	100%
SCHIP Medicaid expansion	186-300%	134-300%	101-300%	101-300%

SOURCE: State of Missouri, Department of Social Services, *Missouri's Children Health Insurance Program Evaluation."* Submitted to the Health Care Financing Administration, March 31, 2000.

NOTES: SCHIP=State Children's Health Insurance Program (Title XXI).

[a] Title XIX Medicaid income standards shown here are net of deductions for a standard work exemption, an earned income disregard, and child care expenses. The Title XXI SCHIP income standards are gross thresholds.

TABLE I.3

INCOME ELIGIBILITY STANDARDS AS A PERCENTAGE OF THE FEDERAL POVERTY LEVEL, PARENT COMPONENTS

	Category			
	TANF Transition Parents	Custodial Parents	Non-custodial Parents	Postpartum women
Traditional Medicaid	None	none	none	185% (60 days)
Section 1115 Medicaid expansion	0-300% (2 year limit)	0-100% (no time limit)	0-125% (2 year limit)	185% (up to 2 years)

SOURCE: State of Missouri, Department of Social Services, *Missouri's Children Health Insurance Program Evaluation."* Submitted to the Health Care Financing Administration, March 31, 2000.

NOTE: Title XIX Medicaid income standards shown here are net of deductions of a standard work exemption, an earned income disregard, and child care expenses.

II. BACKGROUND AND HISTORY OF SCHIP POLICY

The roots of Missouri's SCHIP program extend back to June 1994 when the state first submitted an application to use Section 1115 research and demonstration waiver authority to expand Medicaid coverage to uninsured adults and children with family incomes under 200 percent of the FPL. At that time, strong leadership and political support combined to create a policy window for more progressive reforms. State leaders--including Governor Carnahan, the director of the Department of Social Services, the Medicaid Director, and the Director of the Department of Health--hoped that by expanding the use of managed care arrangements they could generate savings (especially through more efficient use of the state's large disproportionate share hospital outlay) that would support expanded coverage to additional groups. Also, expanding coverage to adults as well as children would make a clear statement about the importance of universal coverage.

But the initial demonstration proposal generated much concern and many questions both within the state and from HCFA, primarily related to the high cost of extending coverage to such a large number of individuals. Even after the state revised the proposal in 1995 to limit the expansion to just children, many questions from HCFA and others remained. Rather than fight all these battles at once, the state decided to let the Section 1115 demonstration proposal sit in the queue for the time being and instead focus on implementing the managed care infrastructure (through Section 1915(b) authority) that would provide the foundation for cost effective coverage expansions. As it turned out, having the Section 1115 proposal remain at HCFA became an advantage later when it came time for the state to implement its SCHIP program.

In late 1995, the state began phasing in its managed care program, which it called Managed Care Plus, or MC+, across the more populated counties along the east-west I-70 corridor that

stretches across the midsection of the state from St. Louis to Kansas City.[2] As of July 2001, managed care had been extended to 37 of the state's 116 counties, with enrollment mandatory for non-disabled populations. Although the state originally planned to implement managed care eventually in all counties, attempts to secure footholds in some of the more rural regions of the state have been unsuccessful, making it likely that fee-for-service arrangements will persist north and south of the I-70 corridor. Statewide, 45 percent of the Medicaid population is enrolled in managed care, with a slightly higher proportion of the 1115 population (58 percent of children and 54 percent of adults) enrolled in such arrangements.

In 1996, with managed care successfully underway, attention turned again to the issue of expanding coverage to more of the uninsured. One option introduced by Democrats in the state legislature would have created a state-funded program, pooling uninsured children and allowing the state to purchase insurance for them at reduced group rates. Republican legislators opposed the idea, suggesting that the state just go ahead and expand Medicaid if it wanted to do anything for this population. Ironically, this rhetoric ended up backfiring on these critics a year later when they were forced to vote on a revised Section 1115 proposal that would do just that for Missouri's SCHIP program.

With federal SCHIP legislation still in development, Governor Carnahan and state Medicaid and DSS leaders decided to revisit the Section 1115 demonstration as a vehicle for reform. Anticipating opposition to broad expansions, they focused coverage expansions on groups with greatest political support: children, working parents, and postpartum women. Under the revised proposal, children would be covered up to 300 percent of the FPL, parents (custodial and non

[2]Over time, the name MC+ became the name for the entire Medicaid program for children and families (both fee-for-service and managed care arrangements).

custodial) would be covered to 100 percent of FPL[3], and Medicaid eligibility for postpartum women would be extended from 60 days to up to 2 years regardless of income. In addition, adults transitioning off of TANF would receive 2 years of coverage as long as their incomes remained under 300 percent of the FPL. Children would receive the standard Medicaid benefit package, while the adults would receive a narrower package similar to that received by state employees. There would be no cost-sharing for any group. With the governor's blessing, these amendments to the demonstration were submitted to HCFA in early 1997, and Medicaid and DSS leaders began holding hearings to garner support for the expansion within the state.

When federal SCHIP legislation passed later that year, the state was ready and moved quickly to get legislation passed in the then democrat-controlled house and senate that enabled implementation of SCHIP as a Medicaid expansion under Section 1115 waiver authority. Additional revisions to the demonstration proposal were then made to comply with state and federal legislation. Most important, state legislation required that the program include cost-sharing and crowd-out provisions. To the surprise of some, who expected this to be negotiated down during legislative debates, the generous 300 percent income threshold for children was retained in the final submission.[4] The retooled Section 1115 proposal and Title XXI SCHIP Plan were submitted to HCFA in September 1997.

Although Missouri was first out of the gates with its SCHIP plan, it was the 12th plan approved because, at this early stage, HCFA was reluctant to grant waivers for Title XXI programs. Eventually the state was allowed to fold the Title XXI children into the Section 1115

[3]The income threshold for non-custodial parents was subsequently increased to 125 percent of FPL.

[4]The 300 percent thresholds are gross income standards. For the Title XXI population, the state applies a standard income disregard equal to 100 percent of the FPL. To be eligible, this net income figure must not exceed 200 percent of the FPL.

demonstration, giving them the higher match for the child expansion. The official estimate of the number of uninsured children eligible under the expansion (based on data from the Current Population Survey) was 91,301, and this was the figure HCFA used to determine the state's allotment. The state estimated that another 78,000 would become eligible under other components of the Title XIX demonstration.

Although views vary about the pros and cons of the Medicaid expansion approach, there was never any serious consideration given to creating a separate state program under Title XXI. At the time, Medicaid generally had a positive image among consumers, and Medicaid and DSS leadership was well-respected by many at the state level and in the legislature. Republican opposition to and critical statements about a separate state program when that idea was first put forward also made it easier for state staff to later argue for a Medicaid expansion. By expanding Medicaid, the state would save on administrative costs, build on the success of its managed care program, and make it easier on families who fluctuate over time from one program or eligibility category to another. Some (including the Medicaid and DSS directors) also viewed the expansion as an opportunity to retool Medicaid and make it more responsive to families and front-line staff. Not everyone was happy about the Medicaid expansion, however. Some worried that such a large expansion would burden already over-taxed front-line workers and put additional strains on already-stressed Medicaid providers. Some opposed the 300 percent eligibility threshold, calling the expansion "Medicaid for Millionaires."

Despite strong opposition among more conservative members of the state legislature, Missouri's ambitious expansion has survived the first three years pretty much intact. A recent proposal to scale back eligibility to no more than 225 percent of FPL never made it to the floor. As one person put it "it is hard to taketh once you giveth." But the recent economic downturn has many worried about the state's fiscal capacity to support the expansion in its present form.

III. OUTREACH

A. INTRODUCTION

Missouri's outreach policies have attempted to strike a balance between getting the word out and minimizing criticism of promotional efforts by those opposed to the program. Strong political forces within the state are opposed to any effort perceived as "outreach for welfare." Another challenge has been to make the messages and other informative materials clear and accurate in the face of complex underlying eligibility guidelines and other program rules. Also, expansions for some groups (children, for example) are less controversial than others (non-working adults), adding further challenge. Overall, it seems efforts have succeeded in getting the word out to a substantial number of eligibles, enabling the state to meet and exceed its enrollment targets. Still, there are critics. Many would like to see a more visible outreach campaign, while there are others who think existing efforts are already excessive.

There was much debate about how to name the program ("It was a huge issue"), and controversy and confusion still exist about this. On the one hand, associating SCHIP with the name MC+ would allow the state to take advantage of the name recognition and positive views about its successful Medicaid managed care rollout, and to avoid an expensive duplication of effort. On the other hand, although over time MC+ had become the name used for the statewide program for children and families, the name said nothing about children and many still thought of it as only managed care. People in areas utilizing fee-for-service arrangements could be confused, and negative views about managed care might also end up tainting the program. After considerable discussion, a trademark search, and focus group testing, state program leaders won approval to call the SCHIP program "MC+ for Kids," enabling them to promote the program as a subset of the larger MC+ program. Advocates and others (including some front line eligibility

workers) still find this name troublesome; in addition to concerns about the link with managed care, they worry that the emphasis on children will confuse parents and other adults eligible for Medicaid under the demonstration or traditional Medicaid rules.

B. STATEWIDE/MEDIA EFFORTS

The statewide campaign for MC+ for Kids has a relatively low profile. State staff described their approach as a "guerilla strategy," stressing the importance of community-based, grassroots efforts and word-of-mouth. Recognizing that "they would get creamed" if they asked the legislature to finance a high-visibility campaign, state staff seem to have charted a more realistic course that makes the best use of limited resources. Staff also observed that, on a political level, the guerilla approach may make it harder for opponents to attack a program that local constituents are working to promote. Promotional efforts build on what was already in place for MC+, refined as needed to reflect feedback from various user groups and changes in program policies. By design, most of the outreach work is taking place at the local level, with state efforts focused on providing tools and infrastructure to support these community-based activities. Components of the state's effort include:

- **Applications and Promotional Materials**. The state produces and distributes a variety of promotional materials in addition to a simplified MC+ application with a special "MC+ for Kids" cover page. (See Appendix B) The state took the lead in revising the application at the onset of MC+ for Kids, and has since revised it several times to reflect policy changes and feedback about ways to make the form clearer and more accurate. The state also takes the lead in designing/redesigning an MC+ for Kids fact sheet and a 2-sided postcard-size information card. Other MC+ for Kids promotional materials include 2 posters and a community education packet for local training activities. Among others, the state gets input on its materials from a consumer advisory group that meets quarterly with state staff.
- **Internet**. The MC+ application and information explaining the program are available on the state's web site, though at this time applications cannot be submitted via the

internet. Recent additions to the web site include an explanation of the various eligibility categories under MC+, MC+ for Kids, and traditional Medicaid. [5]

- **Training Sessions**. Starting in the Summer of 1999, the state has conducted more than 70 training sessions across the state involving roughly 3,000 individuals who have agreed to serve as "ambassadors" for the program, spreading the word to fellow staff members, clients, and others in the community. The state also trained many Department of Health staff to perform tasks similar to outstationed eligibility workers. While the state is open to holding additional training sessions as the need arises, most of the training took place during 1999. In addition to the community education packet mentioned above, other training materials that the state makes available for local trainers include PowerPoint and slide presentations, a training manual, and a video.

- **Outreach Coordinator Meetings**. The state MC+ outreach coordinator travels around the state to distribute materials and meet with staff at local DFS offices, health fairs, hospitals with outstationed eligibility workers, schools, and community-based organizations.

- **Telephone Hotline**. In conjunction with 7 new regional phone centers established to facilitate enrollment for the expansion population, the state established and publicized widely a toll-free telephone number that connects callers with staff who can answer their questions and assist with applications.

- **Media Campaigns**. Though by all accounts, state efforts in this area have been very limited, there have been a few ad-hoc promotions. In response to concerns about lower enrollment levels in some areas, the state purchased radio ads in St. Louis and the Bootheel region. Although the impact of this campaign was not measured formally, enrollment reportedly increased 12 percent after the ads were broadcast.

The state faces many challenges in promoting the program. One of the biggest is helping people (staff and potential applicants) make sense of the many complicated program rules while still ensuring that promotional materials are simple and accessible. Like other states with Medicaid expansions, Missouri has woven new eligibility categories into an already complex program structure. Overall, Missouri's Medicaid program includes 61 distinct eligibility categories, including 31 for pregnant women, children and parents covered under MC+, 5 for

[5] MC+ is the umbrella name the state uses for programs covering low-income pregnant women, children and their caregivers. MC+ for Kids is the name the state uses for the subset of MC+ that involves children (SCHIP and non-SCHIP). "Traditional Medicaid" is the name used to distinguish programs for elderly and disabled populations.

children covered under MC+ for Kids, 4 for uninsured parents brought in under the Section 1115 demonstration, 17 for elderly and disabled people, and 4 for unemployed persons qualifying under state-only general relief provisions. Further complexity stems from differences in verification requirements, cost sharing provisions, and income threshold standards (gross versus net), all of which adds to the difficulty in ensuring that materials are accurate but at the same time not too complex or confusing.

Very little effort has been directed to promoting the parent components of the Section 1115 demonstration, but the word seems to be getting out based on enrollment numbers and the volume of calls to the phone centers from parents with questions about their eligibility. One issue that confused both staff and potential applicants, largely in the first year of the program, was whether parents need to be working in order to qualify under the demonstration program. Although the official policy has always been to cover both working and nonworking parents, there was reportedly some back-and-forth on this in guidance to front line staff and it took time for the message to be conveyed clearly and correctly at the front lines. For the most part, the parent population made eligible under the demonstration is distinct from the child population covered under MC+ for Kids. The former are primarily parents in families with incomes under the federal poverty level, while the MC+ for Kids population is made up entirely of children with higher family incomes. The only exception to this is the TANF transition group, which has an income threshold of 300 percent FPL, though most people transitioning from welfare have incomes closer to the poverty level.

C. COMMUNITY-BASED EFFORTS

As mentioned above, most of the outreach effort for both MC+ and MC+ for Kids is taking place at the community level, with an emphasis on grassroots, word-of-mouth strategies. Posters

are displayed and applications, fact sheets, information cards, and brochures are available in many locations: local DFS offices, schools, hospitals, health centers, health department clinics, community based organizations and other community locations. Other more focused efforts are described below.

Community Partnerships. As an intermediate stepping stone to the community, the state works closely with 8 community partnerships to promote MC+ and MC+ for Kids. The partnerships, which predated MC+ and are focused broadly on addressing the needs of children in a variety of areas, including health, are supported by a consortium of seven state agencies: Health, Mental Health, Social Services, Corrections, Public Safety, Labor, and Economic Development. Three of these partnerships (in Kansas City, St. Louis and Washington County) are also funded by The Robert Wood Johnson Foundation's Covering Kids Pilot Program.

Staff from the lead organization for the St. Louis partnership, ARCHS, reinforced the importance of tailoring outreach to meet the unique circumstances in each community. In the St. Louis region, for example, they described important differences between the city and the county that influence the types of outreach that will be successful. Compared to the county, most of the target population in the city falls within the lower income groups, there are many more African Americans and ethnic minorities, the number of recent immigrants is higher, and in general people tend to be very neighborhood oriented and hesitant to trust government officials. The county, described by one as "a conglomeration of competing fiefdoms," is made up of nearly 100 separate municipalities and is more prosperous, with higher per capita income levels than in the city. We also heard that lower income residents in both the city and the county are accustomed to accessing care for free and not having to submit applications or provide verification. Overall, the St. Louis region is viewed as less cohesive than other regions in the state, particularly in comparison with Kansas City and the state's southwest region. It seemed that more traditional

outreach methods (booths at health fairs, screenings, and other events, distributing various print materials, etc) were the preferred approach in the county, whereas a more neighbor-to-neighbor approach seemed to be preferred in the city.

In the St. Louis region, the effort coordinated by ARCHS focuses broadly on finding and enrolling children and families in MC+ and MC+ for Kids. They utilize a variety of subcommittees that each address a particular type of strategy. Although the focus is ultimately on promoting access to health care for all, special emphasis is placed on reaching families with children. Some of the outreach activities spearheaded by the committees include:

- Establishing partnerships with local employers who do not offer health insurance, to identify potential eligibles
- Developing low-literacy and language-appropriate marketing materials (including a Bosnian translation of the application and instructions)
- Exploring non-traditional approaches to reach harder-to-reach populations (especially recent immigrants and other non-English-speaking populations)
- Partnering with the schools to find eligible families and help them to enroll in MC+

For the school component, subcommittee members have, since 1999, worked with parent liaisons, nurses, and social workers in the St. Louis Public Schools. In addition to educating these individuals about the program, the committee also has an agreement with the school district wherein they receive a list of children participating in the school lunch program who do not appear to have health insurance (based on health forms submitted to the front office). The list of names is then divided up among the parent liaisons, who contact the families to inquire about their interest in applying for MC+. The liaisons also assist with completing the applications, and the ARCHS subcommittee chairperson (who is a DSS employee) provides follow-up assistance as needed to check on the status of the applications. This school program was named a best practice by the Virginia Health Care Foundation.

Marketing by MCOs. Health plans participating in MC+, including MC+ for Kids, are allowed to promote the program within certain limitations (for example, they cannot say "join my plan" and they cannot send out a mailing to a select group of children/families). Some health plan efforts have been very extensive, utilizing television and radio ads, billboards, and the widespread distribution of brochures and other written materials. Although plans must have their materials approved by the state, they are permitted to design their own brochures and other promotional materials. One plan created and distributed 65,000 copies of a brochure with the message "Do you know a child without health insurance?" Plans are allowed to include their logos and contact information on these brochures, along with the MC+ for Kids hotline number and other general program information.

Health plans also partner with community agencies, such as schools and health departments, to promote the program at health fairs and other events. They also work with employers to get the word out about the program, and participate in back-to-school outreach campaigns sponsored by the RWJF Covering Kids initiative.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

While there is little evidence about the effectiveness of specific outreach strategies, and some would like the state to be doing more, enrollment numbers suggest that the state has reached a large proportion of the eligible target population. In late 1999, the state began tracking information about how applicants who go through the phone center learned about MC+. An evaluation of the Section 1115 demonstration, conducted for the state by Behavioral Health Concepts, Inc., reports preliminary data that indicate most phone center users hear about the program from friends, their school or from providers. This finding was reinforced in site visit interviews, as respondents emphasized the importance of word-of-mouth strategies.

Views about the state's low-profile approach to outreach were mixed, with some arguing that more high visibility media promotions should be done and others thinking the grassroots approach is appropriate and that a more visible campaign would put the program at risk in the current political environment. There seemed to be a consensus among people on both sides of this issue, however, that greater publicity would likely be effective in reaching more of the target population.

The lack of a unified statewide promotional campaign has increased the importance of training at the local level, and of ensuring the information and training materials are accurate and appropriate for the target audience. The delay in implementing the state's training program, which got underway roughly a year after enrollment began, contributed to confusion among front line staff during the program's start-up period. Since that time, staff turnover and the continued complexity of the program's eligibility and benefit structure have put continued training high on the list of ongoing needs at the local level. Furthermore, communities and population groups within communities have different needs that necessitate tailored information and outreach methods.

While most people we spoke with believe state staff are doing their best to accommodate these needs at the local level, many felt that more resources were needed to do this work effectively. One telling indication of the diverse ways in which the program is recognized and understood is the number of distinct names currently used to describe the program. Among just the people we met with, we heard the program referred to as: MC+, MC+ for Kids, CHIPS, the waiver program, 1115, and Medicaid. In addition to these names, we heard that families in managed care areas often refer to the program by the plan's name—giving the program another 9 "identities" statewide.

At the local level, we heard that outreach in some communities has been more challenging that in others. In Kansas City and neighboring areas in the southwest region, outreach has been easier in part because communities are less diverse and more unified, local leaders are typically "homegrown," and past successes have resulted in larger funding for local community organizations. Outreach in St. Louis and in many of the very rural communities has been much more challenging. As in other states, adding to the challenge is the lack of reliable local data on the size of the eligible target population. Advocates pressed the state for these figures soon after MC+ for Kids was launched, and the state reluctantly provided the only data available, figures that project county-level estimates of the number of low income uninsured using CPS data and county population numbers. Analysis of enrollment levels compared with the local target population estimates suggests that enrollment rates in the St. Louis region are particularly low. But many of the people we spoke with believe that the target number estimate for St. Louis city is too high, since so many city residents have incomes low enough to qualify under traditional Medicaid categories.

IV. ENROLLMENT AND RETENTION

A. POLICY DEVELOPMENT

Building on Medicaid streamlining efforts that began in the early 1990's and continued with the onset of the MC+ managed care initiative, the state used the launch of MC+ for Kids as an opportunity to improve the image and user-friendliness of the program even further, "to really change the way of doing business," as one state informant put it. State staff also recognized that the program's image and user-friendly enrollment processes would be critical in attracting higher-income families unfamiliar with (and perhaps resistant to) government programs. So in addition to making the application and other program materials accessible and simple to complete, the state created and supported 7 phone centers across the state with staff specially trained to support MC+ enrollment. But as other states have found, simplification is sometimes easier said than done, especially when Medicaid program rules remain complex.

B. ENROLLMENT PROCESSES

Missouri's MC+ eligibility policies are fairly restrictive in comparison with some Medicaid programs, with the important exception of its generous income threshold. Because Missouri's Medicaid expansion is being implemented under Section 1115 demonstration authority, they do not provide retroactive coverage for medical costs that a person may have incurred prior to applying for MC+ for Kids (Table IV.1). Another area where MC+ for Kids differs from traditional Medicaid is in its use of a gross rather than a net income test. The state hoped that by reducing the information and verification needed to calculate net income, the gross income standard would make enrollment easier on families and front line staff. The state does not offer continuous eligibility, so throughout the year families are required to notify their Division of

Family Services caseworker whenever there are changes in income, household composition, residence, or insurance status. The state does not currently offer presumptive eligibility for the MC+ for Kids population, and this was the subject of great debates within the state at the time of our site visit. Since the early 1990s, the state has supported staff in 50 outstationed eligibility sites to help applicants complete Medicaid applications. Most of these sites are located in hospitals and Federally Qualified Health Centers in more populated areas across the state.

The state has had in place since 1992 a 2-page Medicaid application for low income pregnant women, children and their caregivers. The current 2-page MC+ application reflects several rounds of revisions to reflect policy changes as well as improvements in the clarity and accuracy of the contents or instructions. The application is formatted as a 6-sided fold-out, with the application itself printed on the front and back side of one sheet, instructions on 3 other pages, and a cover page labeled "MC+ for Kids Application". Because "MC+ for Kids" appears on all applications, even those for parents and other adults, some advocates and front line workers complained that this contributes to confusion about the program.

As shown in Table IV.2, there are only a few items for which the applicant must provide direct verification: income, immigration status (if applicable), and (for pregnant applicants), a medical statement confirming pregnancy and the expected date of delivery. Initially the state allowed income to be self-reported, but a limited verification requirement (one pay stub, a letter from the employer, or a tax return) was added in mid-1999 in response to concerns of the state appropriations committee about potential application fraud. In addition, applicants who fall within the premium-paying category must submit price quotes from two private insurers that can be used to assess whether the family has access to "affordable" coverage for their children (as of July 1, 2001 the affordability threshold was set at $290 per month). All other information collected in the application is self-reported and verified as needed by state staff using available

state databases. Consistent with federal guidelines, a social security number is only required for the actual applicants. As in other states, however, the state requests (but does not require) social security numbers for other household members because this makes it easier to verify household income levels and assess potential eligibility for other assistance programs.

Completed applications can be mailed, faxed (with the original sent later in the mail) or submitted in person at a local DFS office. Applications are available in many locations throughout the community and can also be obtained directly from a local DFS office, through the phone centers, and on the internet (from the DSS web page). Sometimes phone center staff will fill out an application while talking with the applicant over the phone, though the applicant still needs to sign it and attach income and other verification required before it can be processed officially.

Phone Centers. The state is especially proud of this new component, added with the onset of MC+ for Kids and designed to streamline and facilitate enrollment. In addition to providing additional entry points for applicants who may have trouble coming in to the Division of Family Services during working hours, the phone centers also create some distance and a certain amount of anonymity for people who don't want to be seen accepting government assistance. Staff in the 7 regional phone centers located across the state are DFS employees trained in all aspects of MC+ eligibility and enrollment, and they serve as resources to answer questions and help callers obtain and complete MC+ applications. Additional state resources are provided to support these phone centers. In the three centers we visited, more knowledgeable and experienced staff were selected to work in the phone centers, from among the larger pool of DFS caseworkers, and phone center staff serve as resources for other DFS staff who have questions about MC+.

Callers access the phone centers by dialing a toll-free number, which automatically forwards to the nearest phone center based on the area code and prefix of the initiating phone. Adjacent

phone centers provide backup for each other through a call forwarding set up. On occasion (most often in the St. Louis Region where two phone centers are located within a relatively short distance), there has been some confusion when follow-up calls are routed to a different phone center than the one that handled their original call/application.

Completed applications are processed by DFS staff at regular DFS offices or MC+ phone centers (if someone is applying for or appears eligible for assistance programs other than MC+, the application is processed by a regular DFS case worker). Applications completed at outstationed eligibility sites are faxed or mailed by staff in those sites to the phone centers for processing. The steps involved in processing the applications are described below.

- When staff have all required information, they enter it into a state-linked DSS computer program that automatically "does a budget" and determines an eligibility category for each applicant. DFS staff then enter this along with the effective date of coverage into their local DFS computer system. Information for each applicant is entered and computed separately because eligibility parameters may vary across family members.
- If an applicant is found to be eligible, the state's computer system automatically generates both a letter and a temporary red Medicaid card (that says "Missouri Medicaid") that are sent to the applicant. The red Medicaid card is good for 45 days, at which time the enrollee should have a permanent MC+ card (from the state or from a managed care plan, as described below).
- Each night, the DSS computer downloads a file to the state's enrollment broker, First Health, with that day's new eligibles (along with any cases dropped or modified). First Health then sends the new eligibles an enrollment packet and makes a welcome call to explain the program further and answer any questions.
- If a family falls within the premium category, First Health also sends out an invoice for the monthly premium charge, which the applicant must pay before coverage will take effect.
- In regions with fee-for-service arrangements, the packet from First Health also includes a white ID card that reads MC+ or, for children, MC+ for Kids.
- In regions with managed care, the enrollment packet from First Health also includes information about the health plans operating in their area and explains that the enrollee needs to select a plan within 15 days or they will be auto-assigned. Roughly 25-30 percent of enrollees are auto-assigned to a plan, with some preference in auto-

assignment given to plans that score higher during the biannual bid process (an enrollee's prior connection to a plan is also taken into account).

- After an enrollee selects or is assigned to a plan, First Health notifies the health plan and the plan then sends a packet of information to the enrollee with a new ID card (white, that reads MC+ or, for children, MC+ for Kids, and also has the plan's name on it), and makes a welcome call. The plan's information packet includes a provider directory and the enrollee is told they have 15 days to select a primary care provider.
- If an enrollee doesn't select a provider within this time frame, they are assigned to one by the plan (the auto-assignment percentage varies across plans; for the two plans we spoke with, the rate is roughly 10 percent). While we heard that this varies by region, plans in St. Louis are unable to reach by mail or by phone a substantial percentage of new eligibles (ranging from 30 to 50 percent).

After the first 90 days, enrollees are locked in to their health plan for the remainder of the year. They may, however, switch their primary care provider up to two times at any time during the year.

C. REDETERMINATION PROCESSES

Missouri has taken an unusual approach to handling redeterminations for the MC+ and traditional Medicaid programs. Because the state is understaffed (at 53 percent of need, according to state staff) they cannot conduct annual redeterminations for every enrollee. Instead, they use a triage approach to focus primarily on cases where changes in eligibility status are more likely to have occurred. The priorities for redeterminations are:

- Known changes: such as children who "age out" of the child eligibility categories, cases where the family has notified DFS about a change in household composition (e.g., a new baby) or income (most often when income falls and the family may be eligible for coverage under one of the no-cost or lower-cost categories), and cases where wage or child support data reported to DFS suggests a potential change in income.
- High-risk groups: while the guidelines here did not seem to be very well-specified, in general this would include cases where income levels are lower and/or fluctuations in employment and living situations are more common.

As a general rule, individuals in the MC+ for Kids expansion group are considered to be a lower-risk group, and the state has tried to encourage local DFS offices to focus limited resources on redeterminations for other groups. For the most part, the state feels confident that families in the MC+ for Kids groups will notify DFS when changes in income could reduce their monthly outlay (by moving them from the premium group into the copay only or the no-cost group), and that the volume of changes in the other direction (families moving into the premium group from one of the lower cost categories) is small enough not to merit much attention. While the triage approach is reportedly being applied in many areas across the state, there are some regions (notably, the southwest and some rural areas), where redeterminations are being conducted more comprehensively. To a large extent, the state's approach to conducting redeterminations provides many enrollees with de-facto continuous eligibility.

When the annual review takes place, the DFS case worker mails out a redetermination form that is similar to the application form. Enrollees must complete the entire form, provide verification of current income, and return it to their DFS caseworker within a given timeframe (specified by the case worker; no less than 10 days and typically 30 days). If there is no response by the stated due date, multiple attempts are made to reach the family by mail and/or phone before they are disenrolled. Caseworkers we met with said they also check other possible eligibility pathways (such as checking if teens aging out of children's coverage would qualify under provisions for pregnant women or low income parents) before dropping the enrollee.

A large backlog resulted in a virtual halting of the annual review process during a 6-month period just prior to our site visit. During this period, DFS staff did not initiate any new reviews and instead focused on getting through the stack of existing case files.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

During Federal Fiscal Year 2000, Missouri enrolled nearly 74,000 children in MC+ for Kids, 81 percent of the original target population estimate of 91,301 children (Table IV.3). Furthermore, through August 2001, an additional 70,845 children have been added to Title XIX Medicaid since enrollment in MC+ for Kids began in July 1998. Missouri is also one of 15 states to show a decline in the percentage of uninsured residents during the 1997 to 1999 time period, based on CPS data. The number of parents enrolled in MC+ under the expansion nearly matches the volume of children, with enrollment totaling 89,488 in August 2001. Using the state's adjusted estimate for the size of the target population, which assumes that in the best of circumstances roughly 25 percent would choose not to enroll, the state has already met its target of 68,000 MC+ for Kids enrollees.

These impressive enrollment levels were achieved despite a very limited publicity campaign, attesting perhaps to the strength and effectiveness of local outreach efforts in getting the work out about the program. Time and time again we heard about the importance of word-of-mouth, and the state's successful enrollment experience adds weight to this claim. Many believe that the phone centers have also contributed to the state's enrollment success.

But grassroots promotional efforts have also been quite labor intensive, and have led to variation in how the program is identified and explained. Phone center and other DFS staff, as well as other staff spend a considerable amount of time fielding questions and explaining confusing details about program eligibility and coverage rules. As one respondent put it, "enrolling in this program is an exercise in persistence." The enrollment process in managed care regions is especially challenging, we heard, because enrollees must also make sense of more materials, select both a plan and a provider, and learn about the rules governing how care is

provided in a managed care environment. Problems and confusion can arise in each of these areas, increasing the burden on staff involved in helping enrollees navigate the system.

We heard conflicting information about the extent to which the state has experienced significant problems with disenrollment and retention. On the one hand, the state's relatively unaggressive approach to conducting redeterminations would suggest that enrollment would be relatively stable for most enrollees. Figures reported in annual reports submitted to HCFA indicate a disenrollment rate of between 2 and 3 percent for the MC+ population, a small percentage in comparison with many other SCHIP and Medicaid programs. Thus, despite the lack of a continuous eligibility policy, enrollment appears to be fairly continuous for most MC+ for Kids enrollees. We did, however, hear concerns from some that a significant number of children cycle on and off the program with periods of uninsurance between enrollment spells. Though we were not able to explore this in-depth, it is possible that churning occurs more with children at lower income thresholds who qualify for MC+ under Title XIX provisions--what the state calls its "non-CHIP" categories. That would also be consistent with the state's policy of focusing redetermination resources on cases at the lower income levels, where income and other circumstances fluctuate more often.

Concerns have also been raised about enrollment rates being too low in some regions (St. Louis, in particular), but the data used to back these assertions are quite weak. As in most states, estimates for the number of children eligible under SCHIP are based on CPS figures that are known to have important limitations, most notably that they underestimate substantially the number of children insured through Medicaid. The local estimates were extrapolated from CPS target numbers but are even weaker than the state estimates because they do not account for important variations in local insurance patterns. Most respondents we spoke with felt that the

estimates for St. Louis were much too high because they underestimate the number of very low income children eligible for and enrolled under "non-CHIP" Medicaid categories.

Still, there was widespread agreement that enrollment is more challenging in the St. Louis region and that more could be done to reach potential eligibles and keep them enrolled in the program. This is one reason why providers, advocates and even the Governor are pushing for a presumptive eligibility component under MC+. The way proponents see it, the policy would add additional arms and legs to the state's enrollment team, giving providers and other designated staff the authority to "deem" someone eligible based on self-reported income and related program information. Providers could then serve the person that day--"They're here today, they got the bus fare and the child care today"--and be assured payment for services provided. This, supporters add, may also encourage providers to participate more actively in the program. However, while most agreed that such a policy would be good for providers, not everyone agrees that it would be good for enrollment. Some worry that by "taking the edge off" of the enrollment process, the state may make it too easy for people to put off submitting a formal application. Following our visit, advocates for presumptive eligibility won an important victory when the state Department of Social Services agreed in early September to include the option as a line item in the program's budget for fiscal year 2002. If the legislature approves the budget item (which some believe is unlikely given the state's current financial situation), the policy would apply to children in families with incomes up to 225 percent FPL; entities qualified to grant presumptive eligibility would initially include federally qualified health centers, hospitals, and local health departments.

An important caveat to Missouri's enrollment story is that most enrollment to date has been among children at lower income thresholds—which is consistent with national trends (Rosenbach et al, 2001). Although at 300 percent FPL, the state has one of the highest income

thresholds for SCHIP in the nation, only 5 percent of enrollees have family incomes greater than 225 percent of the FPL. Another 17 percent have family incomes above 185 percent of FPL, but most (78 percent) have incomes below this level. While the reason for this is not clear, some believe that there are more uninsured children at the higher income levels but that existing outreach efforts are not reaching these "non-traditional" families. Premium costs and the 6-month waiting period may also deter some families from applying (discussed further below). Recent increases in the premium levels may make it even more challenging for the state to attract families in the higher income brackets.

TABLE IV.1

SCHIP ELIGIBILITY POLICIES

Policy	MC+ for Kids (SCHIP) Program
Retroactive eligibility	No
Presumptive eligibility	No
Continuous eligibility	No
Income test	Gross
Asset test	Yes ($250,000)
U.S. citizenship requirement	Yes (or qualified alien)

SOURCE: State of Missouri, Department of Social Services, *Missouri's Children Health Insurance Program Evaluation."* Submitted to the Health Care Financing Administration, March 31, 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI).

TABLE IV.2

APPLICATION AND REDETERMINATION FORMS,
REQUIREMENTS AND PROCEDURES

Characteristic	Medicaid[a] and MC+ for Kids SCHIP Program
APPLICATION	
Form	
Joint Form	Yes (MC+/MC+ for Kids)
Length	2 pages (plus 3 pages of instructions)
Languages	4 (English, Spanish, Bosnian, Vietnamese)
Verification Required from Applicants	
Age	No (verified using state database)
Income	Yes
Deductions	No
Assets	No
State Residency	No (verified using state database)
Immigration Status	Yes, for applicants who are non-citizens
Social Security Number	No (applicant must provide number, but it is verified using state databases)
Enrollment Procedures	
Face-to-face Interview Required	No
Mail-in Application	Yes
Phone Application	Yes (but original signature must be provided eventually)
On-line Application	No; application is available to print out from the internet
Hotline	Yes
Outstationing	Yes
Community-Based Enrollment	No
REDETERMINATION	
Same Form As Application	No, but similar
Pre-Printed Form	No
Mail-In Redetermination	Yes
Income Verification Required	Yes
Other Verification Required	No

SOURCE: Various sources used to develop a fact sheet, which state staff reviewed during the site visit.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI). NA=Not applicable.

[a]Children's programs.

TABLE IV.3

ENROLLMENT TRENDS: CHILDREN IN MC+ FOR KIDS (SCHIP)

Enrollment Measure	1998	1999	2000	2001[a]
Number of children ever enrolled in federal fiscal year (October through September)	10,809	49,529	73,825	
Number enrolled at a point in time	December: 24,910	December: 54,306	December: 60,771	August: 75,221
Percent change in point-in-time enrollment	--	+118%	+12%	+24%

SOURCE: Centers for Medicare & Medicaid Services (CMS), "State Children's Health Insurance Program (SCHIP) Aggregate Enrollment Statistics for the 50 States and the District of Columbia for Federal Fiscal Years (FFY) 2000 and 1999"; Vernon K. Smith, "CHIP Program Enrollment: June 2000," Kaiser Commission on Medicaid and the Uninsured, January 2001.

[a]Most recent enrollment data available.

V. CROWD OUT

A. POLICY DEVELOPMENT

Along with cost-sharing, crowd out was a big issue during debates about the MC+ expansion. Many described the two areas as "deal breakers," in that the state legislature would never have approved going forward with the expansion without adequate provisions to prevent crowd out and impose cost-sharing requirements. Concerns about crowd out were especially great because of the program's high income threshold. The state initially proposed a 3-month waiting period, and some argued for it to be as long as 9 months. Ultimately a compromise was reached and a 6-month waiting period was added to the Title XXI plan. The state legislation also required that a focused study of crowd out be included in the mandatory evaluation of the Section 1115 demonstration.

B. PROGRAM CHARACTERISTICS

Although Medicaid rules prohibit imposition of waiting periods, Missouri's Medicaid expansion through a Section 1115 demonstration allowed the state to use a 6-month waiting period as the centerpiece of its crowd-out prevention strategy. Individuals applying for coverage under the demonstration (adults and children), are required to have been without another source of insurance for the 6-month period prior to enrollment. Exceptions to this are granted in cases where the loss of insurance is not voluntary (occurs with a loss of employment, a change to employment that lacks dependent coverage, or the expiration of COBRA coverage).

In addition to the waiting period, applicants who fall within the higher premium-paying income group (226-300 percent FPL), must also provide price quotes from two private insurers for the cost of dependent coverage. This provision was added to prevent families with access to

what the state deems "affordable" coverage from enrolling in the program. The affordability threshold is adjusted periodically and is currently set at $290 per month.

Premium and copayment requirements are considered additional elements of the state's crowdout prevention strategy. Initially, premiums were a fixed monthly amount per family ($68) that was considered by many to be quite affordable. Over time, cost sharing has increased for families in the higher income bracket (premiums went to $80 and recently to as much as $218 for some families; copayments per prescription went from $5 to $9). It is likely, therefore, that current cost sharing requirements will have an even greater impact as a crowd-out prevention measure.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

As required by state legislation, the state included an examination of crowd out in its contracted evaluation of the Section 1115 demonstration. The evaluation drew on several data sources to estimate the extent to which crowd out had occurred among enrollees (children and adults) during the first year of the demonstration (Behavioral Health Concepts, Inc., 2000). Although they found limitations with the available data, the evaluation concluded that the crowd out rate most likely falls in the range of between 1.6 to 3.2 percent, and the "worst case" would be a rate of roughly 10 percent. Interviews with informants throughout the state supported the conclusion that crowd out is not viewed as a significant problem under the demonstration program.

Most of the people we met with were familiar with the evaluation's findings on crowd out and in general agreed with its conclusions. But while many are convinced it's not an issue and would like to see the waiting period reduced to 3 months, opponents of the program still see it as a major concern—several people we met with said they had heard the complaint that "people are

dropping employer insurance so they can buy a new bass boat." Others described situations where families had dropped coverage ("gone bare") for six months in order to qualify for less costly coverage under MC+. Many also were aware of employers who had either stopped offering dependent coverage to some employees or had encouraged employees to opt out of COBRA coverage and sign up for MC+ instead. As one informant noted, "word is out on the street" that DFS is not checking insurance status information, so some applicants are not providing accurate information about current or recent coverage. Discussions with local DFS staff provided some support for this claim, as staff reported that they verify insurance information in a somewhat ad-hoc manner, focusing on individuals with "certain types of jobs" (we didn't learn about the kinds of jobs that were be singled out).

Despite these anecdotes and the lack of strong evidence one way or another, it does seem unlikely that crowd out is a significant problem in Missouri because of the very small number of people in the higher income brackets enrolled in the program. The majority of enrollees have family incomes below 185 percent of FPL, where it is unlikely that many have access to affordable private insurance. The real crowd out problem was expected to occur at the higher incomes, but only 5 percent of total enrollees fall into this group.

VI. BENEFITS

A. POLICY DEVELOPMENT

In implementing its SCHIP program through Section 1115 authority, the state was permitted to modify the standard Medicaid benefit package. But there was very little debate surrounding the decision to offer children under MC+ for Kids nearly the entire complement of Medicaid benefits. The only service excluded was non-emergency transportation services—left out partly because it was thought that the higher income expansion families would have access to automobiles and public transportation, and also because this type of benefit is so uncommon in private sector options. As a condition of approval, HCFA required the state to evaluate the impact of this exclusion on access and health status for children enrolled in the program. Adults covered under the demonstration expansion receive a slightly more narrow package of benefits that is consistent with the benefit package for state employees.

B. BENEFIT PACKAGE CHARACTERISTICS

As noted, children enrolled under MC+ for Kids receive the standard Medicaid benefit package for children except for non-emergency transportation. This includes coverage for the full array of EPSDT services, dental and prescription drugs. Because Missouri's standard Medicaid benefit package for children includes many optional as well as mandatory services, it provides very complete coverage.

The benefit packages for adults covered under the Section 1115 expansion resemble packages typical in the private sector. Notable differences from the standard Medicaid package for adults include more limited dental and optical coverage and no coverage for adult day care, targeted case management, community psychiatric rehabilitation, comprehensive substance

abuse treatment and rehabilitation, dentures, ICF/MR services, nursing facility and personal care services. The benefit package for postpartum women under the demonstration is even more limited, with coverage for only a few services beyond basic primary and preventive care: family planning services and (with limits) ambulatory surgical care, targeted case management, lab/x-ray, nurse midwife, hospital outpatient, personal care, and pharmacy.

C. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Virtually everyone we met with agreed that the children's benefit package under MC+ for Kids is very generous. Virtually identical to the standard Medicaid package for children, it is also considered far more generous than the benefit packages of most private sector options. The concerns, which are in some cases quite serious, are not about the benefits per se but about the extent to which children are able to access needed services (discussed in the next section). With regard to the lack of coverage for non-emergency transportation, we heard that this is not considered a major limitation in the more urban regions but that it does pose problems for children in rural areas of the state. Some managed care plans provide this service anyway because they see it as cost effective in the long run, but managed care is not operational in most rural areas. The state-sponsored evaluation of the Section 1115 demonstration found no negative impact of the exclusion on access and health status for children (Behavioral Health Concepts, Inc., 2001).

VII. SERVICE DELIVERY AND PAYMENT ARRANGEMENTS

A. POLICY DEVELOPMENT

A critical feature of Missouri's expansion approach is the use of managed care arrangements to promote better access and use resources more efficiently, freeing up dollars to finance coverage for children and adults added under the demonstration. In particular, the state hoped to realize significant savings in disproportionate share hospital (DSH) expenditures. At the time managed care was introduced in 1995, DSH outlays in Missouri (at more than $729 million) were the 7th highest in the nation, and exceeded all but 3 other states in the percentage they comprised of total Medicaid spending (25 percent) (Fagnani and Tolbert, 1999). By most accounts, the MC+ managed care launch was considered successful at the time further coverage expansions were being debated, so the demonstration program set out to use managed care as the primary mechanism for meeting budget neutrality requirements under the demonstration.

In addition to the promise of cost savings, managed care was also seen as a way to promote better access. Provider shortages, especially in rural areas, combined with very low reimbursement levels under Medicaid had resulted in significant access problems throughout the state. Under managed care, the hope was that incentives and other health plan efforts to recruit and retain providers would improve access, and also that more care would be coordinated and delivered in appropriate settings. But while managed care has helped the state meet some of these goals, its reach has been limited by negative attitudes among some providers about Medicaid and managed care, serious provider shortages in some regions, and the limited viability of managed care in more rural areas within the state.

B. SERVICE DELIVERY SYSTEM

MC+ for Kids and the other demonstration components utilize the MC+ delivery system, which currently operates managed care arrangements in 37 counties along the I-70 corridor and fee for service arrangements in the other 84 counties. Managed care enrollment is mandatory for non-disabled children enrolled under MC+. There are currently 9 health plans participating statewide: 4 in the western region, 2 in the central region, and 4 in the eastern region (one plan operates in 2 regions). They include a mix of Medicaid-only (2) and plans that also have commercial lines of business. The state used a competitive RFP process to select the initial group of plans (in 1995), and participation has remained relatively stable over time with only one plan dropping out since the program began.

In managed care regions, only a handful of benefits are carved out from managed care contracts and handled under fee-for-service arrangements. Behavioral health services are carved out from managed care contracts. These services include comprehensive substance abuse treatment and rehabilitation services provided under a special arrangement with the C-STAR program, community psychiatric rehabilitation program services, and targeted mental health case management services. The other carve outs include therapy services specified in individual educational or family service plans, environmental lead assessments for children with elevated blood lead levels, bone marrow and organ transplant services, protease inhibitors, examinations associated with child abuse or sexual assault, and abortion services.

Although one plan manages its own network of dental providers, the others subcontract the management of dental services to one of two specialized entities (DORAL and DELTA). All plans also coordinate with the entity selected by the state (C-STAR) for provision of carved-out substance abuse treatment services.

Roughly 5,000 children with special health care needs have been folded into MC+ for Kids, but enrollment in managed care is optional (like it is for other disabled populations) and slightly less than half have opted to remain in fee for service arrangements.[6] The state Department of Health, which manages the Title V program, is responsible for ensuring that special needs children have access to wrap-around services at home, in school and in the community as needed. State Title V program informants report that this requirement is currently being met through EPSDT provisions, which they say should provide coverage for any medically necessary wrap around service (including supplies, equipment, and support services) under MC+.

Community health centers, rural health clinics and other federally-qualified entities play a significant role in providing care for low income populations in Missouri. The state's 14 community health centers and one FQHC look-alike grantee alone serve roughly 23 percent of the state population with incomes under 200 percent of the FPL (NACHC 2001). In addition to these health centers, more prevalent in the state's urban areas, rural health clinics in provider shortage areas provide additional access. Health departments also play a significant role in some areas. Local health departments in St. Louis county and in Cape Girardeau, for example, provide a full range of primary and preventive care services for children and are viewed as key providers for low income families in these areas. Another major safety net provider in St. Louis city, ConnectCare, assumed responsibility for indigent care when the city's large public hospital closed down several years ago. Most of its current funding comes from the city, though it is applying for federal funding as a community health center.

[6]The state was able to transfer most of its Title V special needs caseload into MC+ for Kids because the income eligibility threshold for this program, a 185 percent net income standard, coincides so closely to the threshold applied under MC+ for Kids (300 percent gross; 200 percent net).

State staff report that a large proportion (90 percent) of the state's pediatricians and other private physicians participate in Medicaid and MC+. Other interviews confirmed this but cautioned that many physicians limit severely the number of Medicaid patients they serve, resulting in serious access problems for some populations and/or services. Part of the problem is low reimbursement rates (lower in Missouri than in many other states). Negative attitudes about the Medicaid population, and general anti-managed care sentiments, also reportedly contribute to limiting physician participation. Missouri is predominantly a rural state, and there are widely recognized provider shortages in many of its rural counties. There are also shortages statewide for certain types of services, especially dental and psychiatric care.

C. PAYMENT ARRANGEMENTS

In the 37 managed care counties, health plans are paid on a capitation basis for the vast majority of covered services. There are 18 different rate cells under MC+, with rates negotiated every two years based on bids submitted by the plans. Until recently the rates were based on historic Medicaid fee-for-service payments, adjusted for cost inflation. Now the state uses actual cost data from the plans to adjust and compute acceptable ranges for each rate cell.

Provider payment arrangements under managed care vary across plans and by type of service. Specialty care is reimbursed primarily on a fee-for-service basis, and primary care services are typically covered under capitated arrangements. We heard that rates have increased since the start of MC+, in large part because of successful lobbying by plans and participating providers. Federally Qualified Health Centers are currently paid the same rates as other providers, but they are "made whole" through supplemental payments from the state as warranted following an annual cost reconciliation process.

In December 2000 the state implemented a new policy that adjusts per-member-per-month (PMPM) rates for children based on a plan's EPSDT performance. Consistent with federal guidelines, the new policy calls for an 80 percent EPSDT participation rate (measured as the proportion of enrolled children receiving a screening service during the year). PMPM rates are increased when plans meet this participation target, and reduced when they do not.

Although fee-for-service reimbursement rates have increased significantly since the onset of MC+, providers and even state staff report that reimbursement is in most cases still too low. On average, current rates are reported to be roughly 50-55 percent of Medicare's usual and customary reimbursement levels. Several providers noted that Medicaid payments generally do not cover a provider's overhead costs, and as a result that they limit the size of their Medicaid practice. In addition to pushing the legislature for funding increases in recent years that would permit them to increase rates, the state has placed a special emphasis on increasing rates for EPSDT screenings and dental care, to encourage greater provider participation.

D. IMPLEMENTATION EXPERIENCES AND LESSONS LEARNED

Overall, MC+ and the MC+ for Kids expansion were credited with improving access for a large number of previously uninsured children. Managed care was viewed as having increased the number of providers willing to participate, strengthened lobbying efforts for increased provider reimbursement, given more children a regular source of care, and diverted much care away for emergency rooms and other more costly settings. Some noted that children with special health care needs have better access under managed care because of the increased emphasis on prevention in addition to disease-focused care. Many people noted that state staff have been very responsive and supportive to plans and providers. The state initiated and supports a Quality Assessment and Improvement committee comprised of plan representatives, providers and state

staff that meets periodically to discuss common concerns and identify cost effective ways to improve quality of care. We heard that in people were becoming more receptive to managed care, though anti-managed care sentiments are still strong in some regions (especially rural areas). Although reimbursement under managed care is considered a real problem for many physicians, several informants reported that hospitals are supposedly doing well under MC+.

Still, serious access concerns remain, especially for dental and behavioral health services. Access to primary care physicians is also reported to be a problem in some regions—both rural and some urban areas. There is a statewide shortage of dentists, and in some areas there are reportedly no dentists accepting new MC+ or Medicaid patients. While low reimbursement contributes to low participation, most agreed that the main problem is that more dentists are needed. There is also a serious shortage of child psychiatrists, and many noted problems with the way in which behavioral health care services are handled under managed care. Providers complain about prior authorization rules and referral procedures, which are reportedly more confusing for behavioral health because multiple state agencies (Health, Mental Health, and Social Services) are involved in administering these benefits.

Inaccurate provider directories are another major concern noted by people who work closely with families. Apparently, directories distributed by plans include many providers who no longer participate or who have closed their practices to new patients. This is reportedly a very serious problem with dental providers, but it is also a problem with primary care providers (PCPs). While some families are taking the time to call around until they find someone with an open practice, others end up being autoassigned to another provider when the one they select is not available. We heard that these problems are especially acute in St. Louis city. There are reportedly only 8 to 10 pediatricians in St. Louis city with practices open to serving a significant number of MC+ members.

Like many states, Missouri is struggling to increase its EPSDT participation rates. Most informants we met with see this as a provider education challenge. Apparently, many providers deliver a qualifying EPSDT service but bill it under a different code, such as a comprehensive well-child exam. The state pays more for an EPSDT screen (roughly $60, versus standard visit rate of roughly $27), but many providers don't realize this. The solution as they see it is to make sure providers understand the higher rate structure and make it easier for them to bill for these services. At the time of our visit the state was set to release a new set of EPSDT forms that would walk providers through screening visits more clearly. Whereas use of the earlier version of these forms was optional, it will now be mandatory.

VIII. COST SHARING

A. POLICY DEVELOPMENT

Although the original Section 1115 submission did not include cost sharing provisions, the state legislature would not approve an expansion to 300 percent of the FPL without a significant cost sharing component. Supporters of cost sharing felt strongly that coverage at the higher income levels needed to resemble private insurance, and that cost sharing would also help to discourage crowd out. After much debate, agreement was reached on a set of copayments for those with incomes above 185 percent of FPL and a monthly premium on top of this for those with incomes above 226 percent of FPL. Advocates, state staff and other opponents of cost sharing came to see it as a "necessary evil" for the expansion to move forward. Because cost sharing is all but prohibited under Medicaid rules, the state needed approval from HCFA to implement the expansion under the Section 1115 demonstration.

The state authorizing legislation specifies that premiums be based on the cost of dependent coverage under the Missouri Consolidated Health Care Plan, the statewide plan covering state employees. There has been some confusion, however, about whether this means the total cost of coverage or just the cost borne by state employees. Concerned that premium levels during the program's first 3 years were too low, conservative members of the legislature recently succeeded in getting the state to change the way premiums are set so that the costs more closely approach the full cost of coverage under the consolidated health care plan.

B. PROGRAM CHARACTERISTICS

As outlined in Table VIII.1, there are three major groups with respect to cost sharing:

- a no cost group (family incomes at or below 185 percent FPL)

- a copayments only group (family incomes from 186 to 225 percent FPL)
- a copayment plus premium group (family incomes from 226 to 300 percent FPL)

The copayment for those in the copayment only group is set at $5.00 per visit for applicable professional visits, and this has not changed since the program began. Those in the premium group have a $10 copayment for professional visits along with a copayment for each prescription (originally set at $5 per prescription but increased to $9 in February of 1999). In both groups, there is no copayment for preventive care such as well-child exams and immunizations.

Copayments are collected by providers, and in managed care regions they are backed out of provider capitation amounts. Providers are not allowed to deny services when copayments are not paid, and they are supposed to report instances of nonpayment to DSS. In January 1999, the state received approval to disenroll individuals with a pattern of nonpayment (more than 3 instances annually), but the state has not yet acted on this policy.

Monthly premium levels are adjusted annually. Initially, the premium was a fixed amount of $68 per month per family, and this was increased a year later to $80. Effective July 1, 2001, premiums are now determined on a sliding scale basis depending on income and family size. Premiums now range from a low of $55 to as much as $218 per month, increasing the premium substantially for most families. The new premium structure is designed to bring premiums more in line with costs of coverage under the state consolidated health plan, while still complying with Title XXI requirements limiting cost sharing to no more than 5 percent of total income.

Premium invoicing and collection is handled by the state's enrollment contractor, First Health. The initial premium invoice must be paid before coverage will take effect. After that, invoices are mailed out on the first day of each month and payment is due on the 15th of that month for coverage during the following month. A final notice is mailed by the premium collections unit if payment is not received by the 15th, and a case closure process is initiated if no

payment is received by the 5th day of the month following the due date. As with copayments, the state is allowed to disenroll individuals after they miss more than 3 payments.

C. EXPERIENCES AND LESSONS LEARNED

During the program's first three years, most MC+ for Kids enrollment has been in the no-cost group. Roughly 78 percent of current enrollees are exempt from cost sharing because family income levels are under the 185 percent of FPL threshold. Roughly 17 percent fall into the copayment-only group, and only 5 percent (3,183 as of August 2001) are in the premium-paying group. As mentioned earlier, it is not clear whether low enrollment levels at the higher income levels are due to insufficient outreach, to small numbers of eligible families, to unaffordable cost sharing requirements, or to some combination of these factors. Views about the pros and cons of current cost sharing measures, though, were influenced by the small number of enrollees subject to these provisions.

While there was a consensus about the need for some form of cost sharing, views were mixed about the appropriateness and the impact of current cost sharing amounts. Providers and even advocates agreed that the copayments for professional visits were reasonable, and that this type of cost sharing helps to reinforce the value of health care services. We also heard, however, that the copayments are often not paid. Some providers reportedly are absorbing this as a cost of doing business, while others see this behavior as further justification for limiting their Medicaid/MC+ practice. There were more concerns about the pharmacy copayment. Because the copayment applies to each prescription, advocates and providers alike expressed concern that this is a significant burden on families needing multiple prescriptions filled.

The biggest concerns were about premiums, especially the higher premium levels that became effective July 1, 2001. Supporters say the increase is consistent with the rising cost of

health care in the state and across the country. But advocates and local outreach and enrollment staff worry that the higher monthly outlay will cause many current enrollees to drop out of the program, and discourage others from applying. We heard anecdotes about families who have "gone bare" for six months to qualify for MC+, and because they will not be able to afford the new premium may have to "go bare" again until the open enrollment period for employer-sponsored insurance. We also heard that the higher premium levels will make it even more likely that at the higher income levels only families lacking affordable alternatives for members with chronic conditions will be attracted to the program.

TABLE VIII.1

COST-SHARING POLICIES

Provision	MC+ for Kids SCHIP Policy
Enrollment Fee	No
Premiums (as of 7/01/01)	
▪ Gross income < 225% FPL	None
▪ Gross income 226-300% FPL	Range from $55 to $218 per family per month, depending on family size and income
Copayments (as of 7/1/01)	
▪ Gross income at or under 185% FPL	None
▪ Gross income 186-225% FPL	$5.00 per professional visit
▪ Gross income 226-300% FPL	$10.00 per professional visit; $9.00 per prescription
Penalty for nonpayment	Premiums: first invoice must be paid for coverage to be effective. After this, more than 3 consecutive missed payments results in disenrollment and a 6-month lockout.[1] Copayments: disenrollment with a 6-month lockout after more than 3 reported instances of nonpayment.[1]
Deductibles	No

SOURCE: Mathematica Policy Research staff used various sources to generate a fact sheet, which state staff reviewed during the site visit.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI)

[1] So far the state has not acted on this policy to disenroll families for the failure to meet cost sharing obligations

IX. FAMILY COVERAGE AND EMPLOYER SUBSIDIES

By including low income parents in its demonstration program, Missouri made a bold statement about the importance of covering all family members and not just children. At the time of the site visit, nearly 80,000 low-income parents had become covered under Missouri's Section 1115 expansion. The vast majority (77 percent) have family incomes below the poverty level—so their children are Medicaid eligible under traditional pre-SCHIP rules. While State program leaders had initially hoped to use Title XXI funds for these parents, HCFA approved the use of Title XXI funds only for the expansion children (parents are covered under Title XIX, with the lower federal match).

Missouri does not have programs in place or under consideration to expand coverage for more parents, or to subsidize employer-based coverage. But while many thought that further expansions to cover the higher income parents of Title XXI children would be desirable, virtually everyone agreed that this would not be feasible in the current political and fiscal environment. During legislative debates about the expansion, the parent components seemed to slip through without much attention. According to one outspoken opponent, "the Medicaid budget has exploded" because of the large number of parents brought in under the demonstration. Several people noted that any further expansion to parents would be scrutinized much more closely and there would be strong opposition. Furthermore, the state has spent all of its 1998 allotment, and if enrollment continues at the current pace, Title XXI funds will not be available to fund additional expansions.

X. FINANCING

Missouri implemented its Title XXI program in the last few months of the federal fiscal year (FFY) 1998, and the program grew steadily during the next two years (Table X.1). When the 3-year period for spending FFY 1998 funds ended, Missouri was one of only 12 states to have spent its full allotment. This qualified them for an additional $9.24 million redistributed from the pool of funds unexpended in the other 38 states. With its enhanced federal matching rate of 72.72 percent, Missouri's share of the nearly $52 million in FFY 1998 expenditures amounts to roughly $14 million.

Expenditures under the demonstration, for both the Title XXI and Title XIX expansions, have been higher than projected, creating budget pressures for the state. State staff attributed the spending increase to several factors: enrollment success, huge increases in prescription drug costs, and an overall higher level of per capita costs. In addition to placing strain on already limited state coffers, the cost increases make it more difficult for the state to demonstrate budget neutrality under the demonstration. Another constraint unique to Missouri is known as the Hancock Amendment, which says that unless taxpayers agree to a tax increase, state revenues cannot increase at a rate that exceeds the growth in personal income. A potential fiscal crisis for the current fiscal year was averted at the final hour when the state got approval to use tobacco settlement funds to meet the shortfall. Many are worried, however, about what will happen in future years when costs continue to increase while the economy remains slow and state revenues decline. Some fear that continued budget problems will force the state to scale back the demonstration program.

TABLE X.1

SCHIP ALLOTMENTS AND EXPENDITURES
in millions, 1998-2000

FFY	Federal Allotment	Expenditures	Expenditures as Percentage of Federal Allotment	Percentage of Year's Allotment Spent by End of FFY 2000	Redistributed Amount
1998	$51.67	--	--	100%	
1999	$51.43	$19.7	38%	18%	
2000	$57.98	$41.21	71%	0%	$9.24

SOURCE: Centers for Medicare & Medicaid Services (CMS), Memo from the Center for Medicaid and State Operations to State, January 25, 2000; Federal Register Notice, May 24, 2000; Kenney et al., "Three Years into SCHIP: What States Are and Are Not Spending." Urban Institute: September 2000.

NOTE: SCHIP=State Children's Health Insurance Program (Title XXI); FFY=federal fiscal year

XI. OVERARCHING LESSONS LEARNED

Missouri's ambitious expansion has succeeded in enrolling a large proportion of the target population despite growing fiscal and political pressures. The MC+ for Kids program provides an interesting example of a Medicaid expansion approach that also models private insurance in ways similar to many separate state programs. Contextual elements of Missouri's program are also both fascinating and informative, providing a case study for advancing fairly progressive reforms within more conservative political and fiscal environments. Sustaining the program's generous coverage features and ensuring adequate access are key challenges for the future. Lessons and other observations from Missouri's experiences thus far are summarized below.

- **Capable and respected program leaders make a big difference**. It is difficult to overestimate the importance of strong leadership at all stages of Missouri's program, in building support for the expansion and in skillfully anticipating and largely meeting numerous implementation challenges. Many agreed that the vision and skill of Medicaid and DSS leaders, as well as the governor, were pivotal to securing the generous income threshold as well as the significant expansion for low income parents under the demonstration.

- **The Medicaid expansion approach seems right for Missouri, with the drawbacks well outweighed by its advantages.** Relative to some states, there isn't a strong stigma associated with Medicaid in Missouri; providers, health plans, state agency leaders and legislators respect and have good working relationships with Medicaid and DSS leaders. Even though plans and providers feel strongly that reimbursement rates must be increased, they see Medicaid and DSS staff as competent and very willing to listen to and collaborate with them. Also, the successful managed care roll-out pre-SCHIP gave people even more reason to feel confident about Medicaid and its leadership. The major drawback is that MC+ for Kids is layered on top of already complex Medicaid rules and procedures, making it difficult for front lines staff and families to understand how the various components fit together. But in some ways the complexities of Medicaid may also be an advantage because the workings of Medicaid eligibility and enrollment processes are less accessible and therefore harder to attack.

- **Word-of-mouth outreach is very effective, but other strategies are also needed to build name recognition and to ensure messages are accurate and consistent**. Missouri has pursued a low-profile outreach strategy and the word has gotten out to a

large proportion of the target population. While this strategy has helped minimize opposition among conservative legislators to a more visible campaign, it has also led to greater variation in the messages reaching eligible families and multiple names/identities for the program. Many now argue that strategies such as presumptive eligibility are also needed to bring in harder-to-reach populations.

- **Cost sharing in some form is widely supported and viewed as critical to the program's continued support, but only a small proportion of families are participating in the cost sharing components.** We heard that the copayment burden is often shifted to providers, and very few families are enrolling in the premium-paying part of the program. Recent increases in premium levels have made the program less affordable and have raised questions about whether the program will attract only those with few coverage alternatives (including those with conditions that make them "uninsurable").

- **While SCHIP and earlier Medicaid reforms have improved access for many children and families, serious access problems remain that will likely require broader health system reforms**. The growth in managed care combined with the volume of new enrollees added to Medicaid through the expansion has helped strengthen the delivery system. Plans and providers have helped push for increases in Medicaid reimbursement. Some providers who had been reluctant to participate actively in Medicaid are now more willing because so many more people are covered by the expansion. But reimbursement levels are reportedly still not high enough to cover provider costs. And provider shortages that predated MC+ continue to cause access problems, compounded now because so many more children and families are seeking care under the expansion.

- **State fiscal constraints have many concerned about whether and for how long the expansion can be supported in its current form.** While the program seems to have considerable support now, many noted that greater effort to control costs under Medicaid will be necessary to maintain coverage for the large number eligible for Medicaid under the demonstration and more traditional avenues. When the demonstration program comes up for renewal in 2003, many worry that the program will be scaled back for fiscal reasons.

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APPENDIX A

KEY INFORMANTS

KEY INFORMANTS

ORGANIZATION	NAME	TITLE
State of Missouri	Greg Vadner	Director, Division of Medical Services
	Pam Victor	Deputy Director, Division of Medical Services
	Trisha Schlecte	Deputy Director, Missouri Department of Health
	Marilyn Knippe	MC+ for Kids Program Director (Former Associate Director of Community Relations in DSS under Gary Stangler)
	Denise Cross	Director, Division of Family Services
	Janel Luck	Deputy Director, Division of Family Services
	Billie Waite	Legal Counsel
	Jan Johnson	First Health Services Corporation
	Judy Muck	Assistant Deputy Director for Managed Care, Division of Medical Services
	Donna Siebeneck	Auditor in charge of managed care rate-setting, Division of Medical Services
	Jim Sprague	Provider Services, Division of Medical Services
Care Partners (Health Plan)	David Heitman	CEO
	Cindy Steiner	Supervisor, Membership and Social Services and Utilization Management
	Vicki Meyer	Director, Provider Services and Contractual Relations
	Pamela Wagenar	Director of Medical Management and Regulatory Compliance
	Shirley Rosenberg	Director, Quality Management
	Cindy Wirske	Supervisor, Technical Services
Citizens for Missouri's Children (advocacy group)	Joseph Squillace	Health Policy Analyst
St. Louis ConnectCare Health System	Larry Fields	President and CEO
Cross Trails Community Health Center	Vicki Smith	Executive Director
Department of Health (Cape Girardeau)	Jane Wernesman	Assistant Director
Department of Health (St. Louis City)	Betty Jefferson	Public Health Nurse Supervisor
	Gwyn Jones	Outreach Team Supervisor
	Cynthia Maxey-Brown	Outreach Team Supervisor
Department of Health (St. Louis County)	Joan Bialczak	Director, Division of Health Services
	Carol Shell	Director, Utilization and Quality

APPENDIX A (*continued*)

ORGANIZATION	NAME	TITLE
Division of Family Services (Cape Girardeau)	Bev Long	Area Director
	Marvin Turner	Phone Center Director
	Kathy Jordan	Phone Center Supervisor
Division of Family Services (St. Louis City)	Patricia Allen	Director
	Vera Whirley	Phone Center Supervisor
	Jeannette Robinson	Phone Center Representative
Division of Family Services (St. Louis County)	Bob Fant	Director
	Sharon Minoff	Phone Center Supervisor
Grace Hill Community Health Center	Richard Gram	Executive Director/CEO
Legal Services of Eastern Missouri	Cathy Goldstein	Project Director – the Ombudsman Program (an MC+ consumer advocacy project)
Metropolitan Congregations United	Dr. Katie Plax	Pediatrician
Missouri Care Health Plan	Donna Checkett	CEO
Missouri Hospital Association	Dwight Fine	Senior Vice President, Governmental Relations
Missouri House of Representatives	Patrick Naeger	Representative
Missouri Primary Care Association	Joseph Pierle	CEO
St. Louis Children's Hospital	Dr. Francis Sessions-Cole	Pediatrician
University of Missouri Health Care, Family Health Center (CHC)	Dr. Colleen Kivlahan	Family Doctor

APPENDIX B

APPLICATION

MISSOURI MC+ APPLICATION

COMPLETE IN INK

FOR OFFICE USE ONLY
DATE APPLIED
DCN
SERVICE REP/SUPV/LOAD

A. MAILING ADDRESS

NAME (FIRST, MIDDLE, LAST)

ADDRESS (HOUSE NO., STREET OR RURAL ROUTE, P.O. BOX NO.) | CITY, STATE, ZIP CODE | COUNTY

HOME PHONE NUMBER | WORK PHONE NUMBER | MESSAGE PHONE NUMBER

INSTRUCTIONS: Please answer each question completely. Attach an additional sheet if more space is needed in any section.

B. HOUSEHOLD INFORMATION (LIST ALL CHILDREN, PARENTS/GUARDIANS AND STEPPARENTS WHO LIVE IN YOUR HOME, YOURSELF FIRST.)

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	RACE*/ SEX	HISPANIC Y/N	RELATIONSHIP TO PERSON a.	BIRTHDATE	SOCIAL SECURITY NUMBER	(X) APPLYING FOR MC+
a.			SELF			
b.						
c.						
d.						
e.						
f.						

*(1 - WHITE 2 - BLACK/AFRICAN AMERICAN 4 - AMERICAN INDIAN/ALASKAN NATIVE 5 - ASIAN 6 - NATIVE HAWAIIAN/PACIFIC ISLANDER

1. Are both parents of all the children in the home? ☐ YES ☐ NO (If NO, complete section E.)
2. Are all of the persons applying for MC+ U.S. citizens? ☐ YES ☐ NO If NO, list the following information for persons applying for MC+ who are not U.S. Citizens: Name, immigration status and registration number, date of entry: _____
3. You may qualify for coverage of unpaid bills for medical services received in the past three months. Did any of the persons listed above receive medical services in the past three months? ☐ YES ☐ NO If yes, who? _____
4. Is anyone in your household pregnant? ☐ YES ☐ NO If yes, who? _____ Expected due date? _____
5. Is your net worth (Net worth is the value of everything you own minus any debt.): ☐ less than $50,000 ☐ $50,000-$100,000 ☐ $100,000-$150,000 ☐ $150,000-$200,000 ☐ $200,000 - $250,000 ☐ above $250,000

   Please list your assets (bank accounts, stocks/bonds, vehicles, home, real and personal property, etc.) _____

C. INCOME (Please attach verification; i.e. paycheck stub, note from employer, federal income tax return, award letter, etc.)

1. Are you employed? ☐ YES ☐ NO If YES, name of employer _____

   How much are you paid **before** taxes or deductions? $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly
2. Is anyone else in your home employed? ☐ YES ☐ NO If yes, who? _____

   Name of employer _____

   How much are they paid **before** taxes or deductions? $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly
3. Does anyone in your home operate their own business or are they otherwise self-employed? ☐ YES ☐ NO

   If yes, who? _____ Describe what type of self-employment (baby-sitting, farm income, other) and amount earned: _____ ☐ Weekly ☐ Monthly ☐ Yearly
4. Childcare costs may be an allowable income deduction for working families. Do you pay someone to care for your child?

   ☐ YES ☐ NO If yes, list names of children cared for: _____

   How much do you pay for child care: $ _____ ☐ Weekly ☐ Every two weeks ☐ Twice monthly ☐ Monthly

5. Does anyone in your home receive other income (such as child support, alimony, unemployment compensation benefits, sick benefits, interest income, social security benefits, or other unearned income). ☐ YES ☐ NO If yes, complete the following:

PERSON RECEIVING	WHO PROVIDES THE MONEY?	AMOUNT RECEIVED?	HOW OFTEN RECEIVED?

D. HEALTH INSURANCE

1. Does anyone in your home have medical, hospital insurance or Medicare? ☐ YES ☐ NO If yes, list policies below.

PERSONS INSURED	NAME OF COMPANY AND POLICY NUMBER	TYPE OF COVERAGE
		☐ Doctor ☐ Hospital If limited coverage explain: _____
		☐ Doctor ☐ Hospital If limited coverage explain: _____

2. Has anyone in your home lost health insurance within the past six months?. ☐ YES ☐ NO If yes, provide name(s), date and reason coverage ended. _____

3. Is health insurance available for any member of your family through an employer or other group membership? ☐ YES ☐ NO
If yes, name of employer or group: _____
Is the insurance available for: ☐ self ☐ spouse ☐ children How much is the premium for the children? $ _____ per _____

4. Please refer to the income guidelines sent with the application. If income and family size fall in the premium group, submit 2 quotes from private insurance companies of what they would charge for medical coverage for all of your children.
1. $ _____ per mo. Company _____ 2. $ _____ per mo. Company _____

E. ABSENT PARENT INFORMATION (Complete this section if a parent of any of the children is absent from the home.)

NAME (FIRST, MIDDLE, LAST) (MAIDEN)	RACE/ SEX	SOCIAL SECURITY NUMBER	BIRTHDATE	PARENT OF WHICH CHILD	LAST KNOWN ADDRESS

Do you have a good reason for not cooperating in obtaining support for medical care? ☐ YES ☐ NO
Failure to cooperate does not affect a child's eligibility. (please see instructions for more details)

F. PLEASE READ CAREFULLY AND SIGN BELOW.

- I agree that I must provide Social Security Numbers of all persons applying for MC+ as required by law. The social security number is used to determine eligibility and verify information.
- I agree that my statements and information provided may be verified.
- I will report any changes in circumstances within TEN DAYS of when they happen.
- I know that it is against the law to obtain or attempt to obtain benefits to which I am not entitled. Any false claim, statement or concealment of any material fact whatever, in whole or in part, may subject me to criminal and/or civil prosecution.
- I agree that by applying for (and being determined eligible for) MC+ for a child who is deprived of parental support, I have assigned all rights to medical support to the State of Missouri, and that I must cooperate in establishing paternity and obtaining medical support, **unless I have good cause.**
- I understand healthcare benefits based on a person being age 65 and over, blind or disabled is not determined by completing this application. If I want eligibility for healthcare benefits explored on the basis of being age 65 or over, blind or disabled, I must complete a different application for these benefits.
- I agree that medical information about me and/or my family can be released if needed to administer this program.
- Provided I am found to be eligible for MC+ I know the state of Missouri will pay for covered services on my behalf and agree the state may collect payments from any third party (i.e., insurance, estate, etc.) for services paid by the state.

My signature below certifies under penalty of perjury that all declarations made in this eligibility statement are true, accurate, and complete, to the best of my knowledge.

SIGNATURE	**DATE**	**SIGNATURE OF SPOUSE**	**DATE**

CALL 1-888-275-5908 IF YOU HAVE QUESTIONS